PATIENT'S NAME ____
Last First Initial Date of Birth

1. Purpose of initial visit ______________________________
2. Are you aware of a problem? ______________________________
3. How long since your last dental visit? ______________________________
4. What was done at that time? ______________________________
5. Previous dentist's name ______________________________

Address Telephone

CIRCLE THE APPROPRIATE ANSWER

6. Have you made regular visits? .... YES NO
   How often? ______________________________
7. Were dental x-rays taken? .... YES NO
8. Have you lost any teeth? .... YES NO
   Why? ______________________________
9. Have they been replaced? .... YES NO
10. How have they been replaced?
   a. Fixed bridge ______________ Age ______________
   b. Removable bridge ______________ Age ______________
   c. Denture ______________ Age ______________
11. Are you happy with the replacement? .... YES NO
   If no, explain ______________________________
12. Would you like to know about permanent replacements? .... YES NO
13. Have you ever had any problems or complications with previous dental treatment? YES NO
   If yes, explain ______________________________
14. Do you clench or grind your teeth? .... YES NO
15. Does your jaw click or pop? .... YES NO
16. Have you experienced any pain or soreness in the muscles or your face or around your ear? .... YES NO
17. Do you have frequent headaches, neckaches or shoulder aches? .... YES NO
18. Does food get caught between your teeth? .... YES NO
19. Are any of your teeth sensitive to hot ______ cold ______ sweets ______ pressure ______
20. Do your gums bleed or hurt? .... YES NO
   When? ______________________________
21. How often do you brush your teeth? ______________ When ______________
22. Do you use dental floss? .... YES NO
   How often? ______________________________
23. Are any of your teeth loose, tipped or shifted? .... YES NO
24. Do you have any discolored teeth that bother you? .... YES NO
25. Do you feel your breath is offensive at times? .... YES NO
26. Have you ever had gum treatment or surgery? .... YES NO
   What ______________________________
   Where ______________________________
   When ______________________________
27. How do you feel about your teeth in general? ______________________________
28. Are you happy with the appearance of your teeth? .... YES NO
29. Have you had any unpleasant dental experiences or anything about dentistry that you strongly dislike? ______________________________
30. Do you have any questions or concerns? .... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE..

PATIENT'S SIGNATURE ______________________________ DATE ______________

DENTIST'S SIGNATURE ______________________________ DATE ______________

ANEST.

MED. ALERT

DENTAL HISTORY